Autism Spectrum Disorder (ASD) Screening Test

Patient Information:			
Name:		Date of Test:	
Date of Birth:	Gender:	Contact Information:	
Instructions			
This screening test asse- autism spectrum disorder		aviors and communication skills associated wit	h
Please complete this form	n based on your c	observations and interactions with the patient.	
 Answer each question to accordingly. 	the best of your k	nowledge. If a question is not applicable, mark	it
Screening Questions			
Social Interaction			
Does the patient have diff	ficulty making eye	e contact?	
☐ Yes			
□ No			
Is there a lack of interest	in or difficulty with	n social interactions?	
☐ Yes			
□ No			
Are there challenges in d	eveloping peer rel	ationships?	
☐ Yes			
□ No			
Communication			
Does the patient exhibit of	lelayed speech or	language development?	
☐ Yes			
□ No			
Is there repetitive or stere	eotyped language	or behavior?	
☐ Yes			
☐ No			

 Does the patient struggle with non-verbal communication, such as gestures or facial expressions? 		
☐ Yes		
□ No		
Repetitive Behaviors		
 Does the patient engage in repetitive or ritualistic behaviors (e.g., hand-flapping, lining up objects)? 		
☐ Yes		
□ No		
 Is there an intense focus on specific, narrow interests? Yes 		
□ No		
 Do changes in routine or environment cause distress or resistance? Yes 		
□ No		
Scoring		
• Score each question with "Yes" (1) or "No" (0).		
Total the scores for all questions.		
Results:		
Total Score: (Maximum score:)		
Total Score(Maximum score)		
Interpretation		
Follow-Up		